DOCUMENT RESUME

ED 283 343 EC 192 772

AUTHOR Sargent, Marilyn
TITLE Depressive Disorders: Treatments Bring New Hope.
INSTITUTION National Inst. of Mental Health (DHHS), Rockville, Md. Div. of Scientific and Public Information.
REPORT NO DHHS-(ADM)-86-1491
PUB DATE 86
NOTE 31p.
PUB TYPE Reports - Evaluative/Feasibility (142)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Adolescents; Biochemistry; Children; *Depression (Psychology); Drug Therapy; *Emotional Disturbances; *Etiology; Genetics; Older Adults; Psychotherapy; Suicide; *Therapy

ABSTRACT

This booklet describes the symptoms, forms, causes, and treatment of depression, with particular focus on depression in children, adolescents, and older adults. Symptoms include: persistent sad or "empty" mood; feelings of hopelessness, guilt, or helplessness; loss of interest in ordinary activities; sleep disturbances; eating disturbances; thoughts of death or suicide; and restlessness and irritability. Among the disorders several forms are major clinical depression, dysthymia, bipolar depression (also called manic-depressive disorder), or a combination of disorders. Causes include genetic, biochemical, and environmental factors. Treatments include drug, psychosocial, and electroconvulsive therapy, and (still under study) experimental treatments. Childhood depression may go unrecognized when combined with other types of behavior such as hyperactivity or delinquency. Depression appears to be occurring more commonly among teenagers, whose symptoms are sometimes attributed to the "normal adjustments" of adolescence. Symptoms of depressed older adults are often misdiagnosed as senility or everyday problems of the aged. The depressed person can be helped by family and friends who maintain as normal a relationship as possible, point out distorted thinking without being critical or disapproving, acknowledge that the depressed individual is suffering and in pain, and express affection. Family and friends should not blame the depressed person for his or her condition or say or do anything to exacerbate a poor self-image. (CB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

7804

National Institute of Mental Health

Depressive Disorders:

Treatments Bring New Hope

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

BEST COPY AVAILABLE

ED283343

EC 192772

DEPRESSIVE DISORDERS: TREATMENTS BRING NEW HOPE

By
Marilyn Sargent
Office of Scientific Information
National Institute of Mental Health

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

National Institute of Mental Health
Office of Scientific Information
5600 Fishers Lane
Rockville, Maryland 20857

All material appearing in this volume is in the public domain and may be reproduced or copied without permission from the Institute or the author. Citation of the source is appreciated.

DHHS Publication No. (ADM) 86-1491
Printed 1986

ACKNOWLEDGEMENT

This publication was written with the assistance of the following staff members of the National Institute of Mental Health who took the time to review and comment on its contents: Frederick Goodwin, M.D., Director, Intramural Research Programs (IRP); Robert Hirschfeld, M.D., Chief, Affective and Anxiety Disorders Research Branch (AADRB), Division of Clinical Research (DCR); Irene Elkin, Ph.D., Coordinator, and Tracy Shea, Ph.D., Associate Coordinator, Treatment of Depression Collaborative Research Program, AADRB, DCR; Joyce Lazar, Chief, Prevention Research Branch, DCR; Jack D. Burke, Jr., M.D., Deputy Director, DCR; Jack Blaine, M.D., Research Psychiatrist, AADRB, DCR; Nancy Miller, Ph.D., Head, Clinical Research Program, Mental Disorders of the Aging Research Branch, DCR; and Donald McKnew, M.D., Research Psychiatrist, Laboratory of Developmental Psychology, IRP.

CONTENTS

	Page
Depression is an Illness	1
There are Several Forms of Depressive Disorders	3
Suicide	6
Causes of Depression	7
Treatments	13
Childhood Depression	18
Adolescent Depression	19
Depression Among the Aged	20
Helping the Depressed Person	22
Where to Receive Treatment	24

DEPRESSION IS AN ILLNESS

Mary, who once successfully balanced the demands of a career, motherhood, and wife, can hardly get out of bed these mornings. The simplest chores seem impossible. Thinking and talking are difficult. Former pleasures—making love, eating good food, going to the theater with friends—are no longer enjoyable. She is tired all the time, but has trouble sleeping. Nothing has changed in her life to explain the way she has changed. Her husband is getting impatient, her children feeling neglected, and her boss is threatening to replace her. She feels worthless, helpless, and hopeless.

In contrast to Mary, Jane has not changed very much for years. She has felt somewhat depressed as long as she can remember. She never had the energy or level of concentration needed to complete college or hold a responsible job. When her marriage fell apart, she was left with two small children, little income, and lots of stress. Like Mary, Jane feels sad, guilty, and hopeless, but unlike Mary, she sleeps and eats too much.

John is disillusioned with his life. He's bored with his job and his marriage. He feels trapped and angry, and doesn't hold much hope for the future. Fearing that his problems would be seen as "weakness," John won't talk to anyone about them and tries to drown his overwhelming sadness in alcohol.

Jim is on an emotional roller coaster. Sometimes he's so low, he feels that suicide is the only way out. At other times, he thinks he can conquer the world. Unfortunately, when he's feeling most invincible he behaves irrationally, going on spending and traveling sprees, staying up all night and talking ceaselessly.

Ann is 80 years old. Three years ago, her husband of over 50 years died. Shortly thereafter, her last living sibling—her sister—also

passed away. Since then she has become confused, forgetful, and appears satisfied to sit in one place staring into space for hours on end. Her children are concerned that their once alert and active mother has become senile.

Mary and all the others described above are suffering from a depressive disorder. They are not lazy, misanthropic, senile, or unusual. They are ill and so are nearly 10 million other Americans: Depressive disorders are among the most prevalent of the mental illnesses, affecting people of all ages, socioeconomic classes, races and cultures. *Fortunately, depressive disorders are also among the most responsive to treatment; almost 80 percent of all serious depressions can be successfully alleviated.* Nevertheless, relatively few of its victims seek help.

Too many people suffer needlessly, not recognizing that their pains and aches, their exhaustion and sleeplessness may be symptoms of an underlying depression. Some individuals put off getting help because they expect their symptoms to go away as have their blue moods in the past.

But depressive disorders should not be confused with the transient feelings of unhappiness that everyone experiences—the periods of sadness associated with unhappy events and failures, or the emotional letdowns that occur commonly in the spring or fall or around holidays. Nor should depressive disorders be confused with the intense grief brought about by the loss of a loved one. Sadness and grief are normal and temporary reactions to life's stresses; time heals, the mood lifts, and people continue to function.

In contrast, individuals afflicted with a depressive disorder do not feel better for months, sometimes for years. Depressive disorders affect feelings, thoughts, and behaviors. Their symptoms include:

- Persistent sad, anxious, or "empty" mood
- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness

- Loss of interest or pleasure in ordinary activities, including sex
- Sleep disturbances (insomnia, early-morning waking, oversleeping)
- Eating disturbances (changes in appetite and/or weight loss or gain)
- Decreased energy, fatigue, being "slowed down"
- Thoughts of death or suicide, sucide attempts
- Restlessness, irritability
- Difficulty in concentrating, remembering, making decisions

Anyone who experiences four or more of the above symptoms for more than two weeks, or whose usual functioning has become impaired by such symptoms, has a depressive disorder that should be treated.

THERE ARE SEVERAL FORMS OF DEPRESSIVE DISORDERS

In some people, depressive symptoms begin suddenly and seem to have no relation to what is happening in their lives. With no apparent reason, they can no longer function as usual. Like Mary, they are experiencing an episode of clinical depression, in this case a major depressive episode (symptoms are severe). In fact, some mental health experts suggest that the key feature of clinical depression is change—the former man-about-town loses interest in women; the once social woman becomes reclusive. Furthermore, the change persists. Without treatment, the loss of interest in sex or food, the changes in sleep patterns or mood, or other symptoms experienced by clinically depressed people may continue for months, even years.

Although some people have only a single episode of clinical depression in a lifetime, it is more commonly a recurrent disorder. The more recurrent forms of clinical depression can require maintenance on medication to prevent new episodes from occurring.

Clinical depression also can occur following a loss, such as in Ann's case, or

166-211 O - 87 - 2 : QL 3

by a mid-life crisis as with John, or even by giving birth (once referred to as post-partum depression). It is not unusual for important life events to be associated with depression, but "normal" depression is not as severe or lasting as clinical depression nor is it manifested by dramatic behavioral change.

Others, like Jane, seem to be depressed all their lives. Their symptoms aren't as severe as Mary's, but drag on for years, keeping victims from ever feeling really well. They are suffering from dysthymia, a disorder once called neurotic depression. Some people with dysthymia also have episodes of major depression, their symptoms becoming dramatically more severe for awhile and then returning to their usual reduced level. These people are said to have double depression; that is, dysthymia *plus* major depression. Individuals with double depression are at much higher risk for recurring episodes of major depression, so careful treatment and follow-up is very important.

Jim is a victim of bipolar depression, also called manic-depressive disorder. He experiences alternating bouts of depression and mania. When depressed, individuals like Jim can experience any of the symptoms associated with major depression. When in a manic phase of the cycle, they experience feelings of elation, insomnia, and increased talking, social, sexual, and physical activity. The manic person possesses abundant energy, has grandiose notions, and feels capable of carrying out any undertaking, tending to overlook painful and harmful consequences. In extreme cases, individuals may experience thought disorder, jumping from one idea to another with no apparent connection, sometimes to the point of delusions and hallucinations.

Delusions are not limited to mania, however. When a clinical depression becomes especially severe, delusions are not uncommon; depressive delusions represent exaggerations of helplessness, hopelessness, or guilt, such as believing

that one is responsible for all the evil in the world.

Clearly, depression comes in various forms, sometimes referred to by various terms. Depending on whether a patient is talking to a clinician, researcher, or other mental health specialist, his or her disorder may be referred to as *clinical, major, unipolar* or *endogenous.* These differing terms can be confusing if the patient doesn't realize that they are overlapping and not mutually exclusive.

The term "clinical" is a general term applied to any depression where symptoms are severe and lasting enough to require treatment. "Major" indicates a clinical depression that meets specific diagnostic criteria as to duration, functional impairment, and involvement of a cluster of both physiological and psychological symptoms. "Unipolar" means that the individual suffers from major depression, but not from manic-depressive disorder, which is called "bipolar" illness. "Endogenous" is used to designate forms of depression manifested by a cluster of the more biological symptoms, such as sleep disturbance and weight loss.

To make matters even more complex, depression is very often associated with other disorders, such as anorexia, anxiety, and obsessive-compulsive disorders.

While defining depression is of major importance to researchers, the overriding concern of patients is to get well. Since there are a variety of available treatments and medications that alleviate depression (see TREATMENTS), finding the right one(s) for a specific patient may require several trials. Clinicians should be willing to reevaluate treatment if symptoms do not begin to lift within a month or two. In some cases, people should consider getting a second opinion.

Severe depression can actually keep victims from seeking needed help. Some lack the energy to take the initiative and some view their symptoms as a deserved punishment or their own fault. This can be especially true if family and friends take this viewpoint.

In fact, family and friends should encourage

the depressed individual to seek treatment. He or she may need to be convinced that help is possible and, if suicidal feelings are present, urgently needed. Without offering false hope, the depressed person can be informed that 80 percent of depressed patients can be successfully treated, and researchers are seeking answers for the 20 percent who do not respond to available therapies.

SUICIDE

The possibility of suicide is the most serious complication of depressive disorders. Feelings of worthlessness and guilt, combined with a special kind of psychic pain, overcome the individual, and he or she feels unable to go on or unfit to live. Sometimes these feelings remain just thoughts, and at other times they lead to suicidal attempts.

Not all those suffering from depressive disorders attempt suicide, nor are all those who attempt suicide suffering from a depressive disorder. It is estimated that 15 percent of depressed persons may eventually commit suicide, and among suicide victims, more than half are suffering from a depressive disorder. The person hospitalized for depression at some time in his life is about 30 times more likely to commit suicide than is the nondepressed person, with the greatest risk during or immediately following hospitalization.

The possibility of suicide increases with advancing age. In recent years, however, there have been alarming increases in suicide among young adults. Approximately twice as many women as men suffer from depressive disorders, and nearly twice as many women attempt suicide; however, men are two to three times more likely than women to actually kill themselves.

CAUSES OF DEPRESSION

Genetic Factors.

Although the exact mechanisms by which depressive disorders are transmitted from one generation to another are not yet known, there is growing evidence that a genetic factor is involved, especially in the more recurrent forms of the disorder.

Studies have shown that if one identical twin suffers from an affective disorder (depression or mania), there is a 70 percent likelihood that the other twin also will be afflicted. Among nonidentical twins, however, as with siblings, parents, or children of the afflicted person, the risk decreases to about 15 percent. Among second-degree relatives, such as grandparents, uncles, or aunts, the risk of affliction drops to about 7 percent. Since identical twins have all their genes in common, siblings and other first-degree relatives have only half in common, and second-degree relatives even fewer, the affliction rates attest to genetic involvement.

Perhaps even more suggestive of a genetic factor are studies of adoptees carried out in New York, Brussels, and Denmark. The New York/Brussels researchers identified adopted individuals who had been diagnosed as having a depressive disorder and then compared the incidence of diagnosed depression in biological and adoptive parents. They found higher correlations between depressed adoptees, particularly those with bipolar depression, and their biological parents than with those who adopted and raised them from early childhood.

The Denmark study, which included first- and second-degree relatives of both biological and adopting families of depressed individuals, found a higher concentration—three times greater—of depressive disorders among biological relatives than were found among the adopting families.

While the higher incidence of depressive disorders in biological families gives credence to a genetic factor, some believe family environment also may play a role. This theory holds that a person

brought up in a household with a depressed or manic individual may learn by example to handle stress in an abnormal manner. Also, other environmental as well as biochemical influences may contribute to the vulnerability to depressive disorders.

Biochemical Factors.

Some 30 years ago, physicians first observed that certain medications had strong mood-altering properties. Depression was observed in patients taking reserpine, a drug to control blood pressure. In contrast, iproniazid, used to treat tuberculosis, was associated with euphoria in some patients.

The implication of these observations—that mood disorders could be a function of a biochemical disturbance and could be stabilized by drugs—prompted clinical and laboratory studies that have revolutionized the treatment of mental disorders. Three types of drugs, the tricyclics, the MAO inhibitors, and lithium, are now available to help alleviate the suffering of individuals with depressive disorders.

In addition to the efficacy of the antidepressant drugs, further evidence of biochemical disturbance in depressive disorders has been found in animal brain tissue studies. A group of chemical compounds, the biogenic amines, has been shown to regulate mood. Two of the amines which appear to be of particular importance, serotonin and norepinephrine, are concentrated in areas of the brain that also control such drives as hunger, sex, and thirst.

Serotonin generally serves inhibitory functions in the brain, and disturbances in its functioning may underlie the irritability, anxiety, and sleep disturbances common to depression. Norepinephrine is released by nerve cells in the brain when a person takes amphetamines and gets "high." Under normal conditions, it is involved in the maintenance of arousal, alertness, and euphoria. Disburbances in norepinephrine function in depression are thought to underlie lack of energy and depressed mood.

Serotonin and norepinephrine are among the many chemical compounds

identified as neurotransmitters, the chemical "messengers" that transmit electrochemical signals from one nerve cell in the brain to another. Neurotransmitters set in motion the complex chemical interactions that control our behaviors, feelings, and thoughts.

Research suggests that a depletion, abundance, or some improper balance of neurotransmitters available in the brain are related to the symptoms and episodes of depression and mania and that drugs work by correcting the imbalances. The tricyclics and the MAO inhibitors increase the availability of neurotransmitters, and this may be the mechanism by which they can counter the symptoms of depression. Lithium's anti-manic action may derive from its ability to inhibit the release of certain neurotransmitters. How lithium also effectively controls depressive episodes and can prevent both manias and depressions is not yet known.

Besides chemical disturbances, certain physiological changes are also associated with depression. Muscle tension and heart and respiration rates may increase. Cells retain more salt than usual, bringing about an imbalance in the electrical charges within the nervous system. Changes in the production of a hormone, cortisol, also have been observed in depressed persons. Cortisol production generally follows a pattern of peaking in the early morning, leveling off during the day, and reaching its lowest point in the early evening. Cortisol levels also increase when the body is exposed to stressful situations, such as extreme cold, or when an individual is feeling angry or frightened. In depressed individuals, the hormone peaks much earlier in the day than is normal and remains high all day.

The high levels of cortisol may explain the sleep disturbances experienced during depressive episodes. Studies show that depressed people miss the most restful stage of sleep.

Whether the physical and mood changes associated with depressive disorders are caused by biochemical factors or whether the disorder

causes the biochemical disturbance is not known. Possibly, biochemical imbalance may represent a genetic vulnerability set in motion by prolonged stress, trauma, physical illness, or some other environmental condition.

Environmental and Other Factors.

Financial problems, physical illness, hormones, midlife crises, sex role expectations, and such psychosocial phenomena as personality, upbringing, and negative thinking style have been cited as contributors to depressive disorders.

Any change, serious loss, or stress—a divorce, the death of a loved one, the loss of a job, or move to a new home—can trigger depression, usually temporary but sometimes requiring treatment to alleviate symptoms.

Perhaps most suggestive of environmental/psychosocial factors in depression is an examination of the populations that appear to be particularly vulnerable. For instance, up until age 65, twice as many women as men are treated for depressive disorders, with the exception of bipolar disorder which occurs equally in both sexes. After 65, the depression rates begin to equalize between the sexes as more men become depressed.

Some experts believe retirement contributes to the higher rate of depression among older men who have been brought up to see their self-worth in terms of work and productivity or who have been too tired or pressured to develop interests and skills other than those found in the workplace. Boredom and the loss of self-esteem associated with retirement may compound the other conditions of the elderly—poor health, waning strength, death of friends and loved ones—to make the older man more vulnerable to depression.

Among women, the highest rates of depression are found in young, poor mothers of small children who are single heads of households. These women, faced with raising children with little if any emotional and financial support, appear particularly vulnerable to depression. Lacking the assistance and

company of a caring companion, they suffer loneliness and unrelieved responsibility for childcare and household maintenance.

Families headed by single women are among the poorest in the country, and their numbers, reflecting increasing divorce rates, are growing. Factors contributing to their poverty are inadequate finances, lack of child support payments, and the women's inability to earn income sufficient to make ends meet. Too often, these young women have left school prematurely and lack the educational skills required to gain access to higher paying jobs. Then, too, unless they can arrange affordable childcare, they may not be able to work at all.

The stresses facing women today might seem to contribute to their high rates of depression. Yet some experts argue that women are not more vulnerable to depression than men, but just deal with their symptoms differently. Women, they say, are more apt to admit feelings of depression and seek professional assistance, whereas men may be socially conditioned to repress such feelings or to bury them in alcohol, as reflected in the higher rates of alcoholism among men.

On the other hand, social conditioning also has been cited as contributing to the higher incidence of depression among women. One theory suggests that young girls are taught to be helpless and therefore are vulnerable to depression when faced with the realities, problems, and decisions of adulthood. According to the "learned helplessness" theory, female children are either ignored or punished for taking control of situations. By implication, girls learn that take-charge behaviors suitable for boys are considered unfeminine or not "nice" for girls. Studies show that individuals discouraged from acting on their own behalf tend to become passive and eventually avoid responsibility. A vicious cycle is set in motion, say the theorists: Passivity leads to lack of control which leads to feelings of helplessness and depression.

In addition to the psychosocial explanations for

higher rates of depression among women, hormonal functioning also is considered a possible influencing factor. Post-partum depressions, which range from serious incapacitating episodes to transient blues following childbirth, seem to point to a hormonal component, but the biological mechanism that would explain hormonal involvement has yet to be discovered. Menstrual cycles have been associated with depressed feelings, irritability, and other behavioral and physical changes in some women. Referred to as premenstrual syndrome, it has become the subject of recent research and much controversy about its causes, implications, and relation to depressive disorders. The answers will no doubt emerge as researchers apply their expertise to this long-ignored condition.

At one time, mental health experts believed that women who experienced depression during change of life were suffering a special kind of depressive disorder referred to as involutional melancholia, a diagnosis no longer in use. Research has shown that depressive disorders at menopause do not differ from those experienced at other ages and that women most vulnerable to change-of-life depression typically have a history of past depressive episodes.

The "empty-nest syndrome" also has been offered to explain change-of-life-depression. The theory is that when children grow up and leave home, women who have devoted their lives to raising them feel useless, or no longer needed, and bereft of ego-supporting activities, much in the way that some men respond to retirement. While changes of any kind can trigger depression in vulnerable people, the lack of increased rates of depression among women at this stage of life suggests that most do not get depressed.

Midlife crisis, the time of evaluation of the past, when people ask that fatal question, "Is this all there is?" has been associated with depression in both sexes.

Whatever the cause, treatment for depression is at hand. In most cases, individuals no longer need suffer or remain nonfunc-

tional due to the symptoms of depression.

TREATMENTS

Depressive disorders are among the most responsive to treatment of the mental disorders. Advances in therapy have helped to alleviate and minimize the symptoms and mood complications of depression enabling many persons to lead normal lives. A variety of treatments is available, and the mode chosen depends on the patient's condition, diagnosis, or personality. The three basic types of treatment—drugs, psychosocial therapy, and electroconvulsive therapy—may be used singly or in combination.

Drug Therapy.

The three categories of drugs prescribed for depressive disorders are the tricyclics and MAO inhibitors, useful in alleviating a wide range of depressive symptoms, and lithium for controlling manic-depressive illness and the more recurrent forms of unipolar depression. Since response to drugs varies with each individual, trials with several or combinations of drugs may be necessary to determine which works the best with the fewest side effects. Most antidepressant side effects, such as dry mouth, drowsiness, and constipation, occur early in treatment, and subside as the body adjusts.

The tricyclics alleviate such symptoms as loss of appetite and weight, decreased capacity to feel pleasure, loss of energy, psychomotor retardation, suicidal thoughts, and thought patterns dominated by hopelessness, helplessness, and excessive guilt. Depressive symptoms can be alleviated in days or weeks, depending on which tricyclic is used.

The other group of antidepressants, MAO inhibitors, is more likely to be useful for patients whose depression is characterized by increased appetite and excessive sleepiness. Persons who experience high levels of anxiety, hypochondriacal, phobic, and obsessive-compulsive characteristics, in addition to depression, may also

respond well to MAO inhibitors.

Lithium is generally most effective in reducing the frequency and severity of manic-depressive cycles; lithium is to manic-depressive illness what insulin is to diabetes. In a recent NIMH study, at least 70 percent of the manic-depressive patients maintained on lithium stopped having episodes or had fewer, shorter, or less severe ones. It has been found that some persons experiencing depression, particularly those who have a family history of mania, also respond favorably to lithium.

Most of the manic-depressive patients who do not respond to lithium have rapidly changing cycles and can generally be helped by the addition of carbamazepine.

Maintenance on medication is essential for persons with recurrent forms of depression, particularly manic-depressive disorder and recurring episodes of major depression. Such continuous treatment can offer essentially normal functioning to those whose lives might otherwise be painful beyond endurance.

Psychosocial Therapies.

Psychosocial therapies come in many variations and are offered for groups, families, couples and individuals. There are "talking" therapies during which problems are discussed and resolved through the emotional support, insights and understanding gained from the verbal give-and-take. Other therapies concentrate on behaviors: patients are taught to be more effective in obtaining rewards and satisfaction through their own actions. Some therapies examine the past, seeking resolution of present problems by shedding light on earlier experiences. Others strictly focus on current conflicts and interpersonal problems.

Currently, among the most widely used forms of psychosocial therapy are those referred to as psychodynamic. Such therapies are based on the assumption that internal conflicts, such as conflicted feelings (e.g., wanting dependence and independence, hating and loving the same person), are at the heart of the patient's disorder. Resolution of such conflicts is

essential to successful treatment. Unresolved conflicts are often rooted in early childhood, many evolving from child-parent relationships. A key aspect of the treatment involves bringing the conflict into the therapeutic situation where it can be dealt with and resolved. Psychodynamic therapy is typically open-ended in terms of time, but new short-term versions also are used to treat clinical depression.

A recent study compared the efficacy of two specific short-term (16-week) psychosocial therapies—cognitive/behavioral and interpersonal—with the tricylic drug imipramine for treatment of clinically depressed outpatients. While the relief of symptoms began earlier on the drug, patients receiving the psychosocial treatments were equally symptom-free by the end of 16 weeks. The drug and interpersonal therapy were both efficacious for the more severely depressed patients. For patients who cannot or do not wish to take drugs for various reasons, the findings of this study are very good news.

Even more important, perhaps, are the clues beginning to emerge from this ground-breaking study about which patients do best on which treatments. Mental health clinicians have long hoped for scientifically-based criteria to identify the best treatment for specific patients. The first steps have been taken to analyze information on the relationship of specific patient characteristics to specific treatment outcomes, but much more work remains to be done before definite answers are available.

Cognitive/behavioral therapy is based on the premise that people's emotions and behaviors are determined by how they view the world and interpret their experiences. Depressed persons tend to think negatively about themselves, the world, and the future. They expect to fail and often make faulty inferences about the behaviors and thoughts of others. The cognitive therapist uses a variety of strategies to help patients correct maladaptive beliefs and negative thought patterns. The promotion of

more realistic and logical thinking enhances behavioral and mood changes. Therapists also may use behavioral methods to help patients increase their activity levels and gain targeted behaviors.

Interpersonal therapy is based on the concept that depressive symptoms occur in the context of disturbed personal and social relationships. Such disturbed relationships may cause or perpetuate depressive symptoms which, in turn, exacerbate interpersonal problems; a dysfunctional cycle is underway. Focusing on current issues, interpersonal therapists help patients understand their illness, their feelings, and how interpersonal problems and conflicts relate to their depression. Patients are encouraged to identify and better understand such problems and to develop more adaptive ways of relating to others.

In addition to cognitive/behavioral and interpersonal therapies, many other forms of psychosocial and behavioral therapies are used to treat depression. Some experts maintain that the patient-clinician relationship is more important for treatment success than the form of treatment used, but this issue has not yet been specifically studied with depressed patients.

Also, for some patients combinations of treatment are most effective, i.e., medications to control symptoms and restore functioning and psychosocial therapy to address the social and behavioral problems that go with serious depressive disorders. More clinicians are becoming adept at providing the multiple approaches often needed to help severely depressed people.

Electroconvulsive Therapy.

With the availability of psychoactive drugs, use of electroconvulsive therapy (ECT) has declined. Nevertheless, ECT remains a very effective treatment for major endogenous depression and mania (it is not effective for dysthymic depression), particularly in the following circumstances: the individual is severely depressed, is at high risk for suicide, is severely malnourished,

does not respond to drugs, or, as commonly occurs among the elderly, cannot tolerate the drugs or cannot take them because of a medical problem such as a heart condition.

Current ECT practices are designed to bring symptomatic relief with minimal discomfort. The patient is briefly put to sleep with an intravenous anesthetic, ensuring that the procedure is painless and not experienced or remembered. A muscle relaxant is administered to minimize muscular response when the electric current is applied.

Electrodes are placed either on both sides of the scalp (bilaterally) or on one side of the scalp (unilaterally) on the "nondominant" side of the brain (usually the right side). There is substantial evidence that unilateral electrode placement over the nondominant hemisphere produces less disruption of memory and less confusion following treatment. However, there is also some evidence that unilateral nondominant placement may be less effective or require more treatments than bilateral placement.

Also, the age of the patient and the length, spacing, number of treatments, and intensity of electric current administered influence memory loss and confusion—the lower, the better. However, even under optimum conditions, patients experience transient memory loss for events surrounding the treatment—most often for those occurring 6 months to a year before the ECT treatments. The ability to learn new information during and immediately after ECT also can be temporarily affected, but is typically regained after several weeks.

Experimental Treatments.

Some patients who experience depression during the winter (often with mild highs during the summer) are thought to have Seasonal Affective Disorder (SADS), a condition associated with exposure to daylight. The treatment involves sitting for several hours each day under special lights designed to approximate daylight. They provide about three times the brightness of ordinary artificial room light.

Several research centers are studying this new treatment and report considerable success with the appropriate population.

Researchers also are experimenting with modifying sleep patterns in depressed patients. Keeping patients up for 24 hours or, in some cases the second half of the night, has temporarily alleviated depressive symptoms for a day or two in some people. Some depressed people, particularly those whose sleeping patterns have been severely disrupted by depression, are helped by advancing the time period during which they sleep. This treatment is thought to "reset the biological clock" involved in controlling normal life rhythms, such as eating and sleeping cycles and the production of internal hormones, all of which can be disrupted during depressive illness. Whether the disruption of the biological clock is caused by or causes depression is not yet known.

CHILDHOOD DEPRESSION

Normal behaviors vary so much from one childhood stage to another that it sometimes is difficult to know whether a child is suffering from depression or just going through the terrible twos, sulky sevens, or the trying teens. Also, temporary interludes of depression, when things go wrong, are just as common among children as adults.

But a depressive disorder may be indicated if symptoms similar to those seen in depressed adults—sadness, apathy, sleeping and eating disturbances—continue for several weeks. In cases of severe depression, children may also experience feelings of hopelessness and despair, and harbor suicidal thoughts.

Childhood depression may be unrecognized or misdiagnosed when depressive symptoms are mixed with other types of behavior, such as hyperactivity, delinquency, school problems, or psychosomatic complaints. A closer examination of a child's

thinking and functioning may reveal underlying depression and feelings of worthlessness.

The loss of love or attention from someone on whom a child is dependent for care and nurturance may precipitate a depressive episode. The loss may be caused by the death or prolonged absence of the beloved persons. In some cases, the caretaker remains physically present but for some reason withdraws emotionally from the child.

Depreciation and rejection of the child by a caretaker also are important factors in many cases of childhood depression. Most childhood depression, however, is not caused by a single precipitating incident or factor, but is usually associated with genetic vulnerability and ongoing environmental stresses.

Children identified as especially vulnerable to depression include those of manic-depressive parents or of parents hospitalized for a chronic physical illness. Hospitalized children, particularly those with a chronic illness, are also at risk.

The importance of treating depressed children has been shown by several studies which indicate that untreated childhood depression may lead to subsequent problems in adolescence and adult life.

Parental counseling and family therapy are commonly used methods for helping the younger depressed child. Through providing emotional support and guidance to family members, the mental health professional can facilitate the child's recovery.

Children over 8 years of age usually participate in family therapy. In some situations, individual treatment may be appropriate for older children.

Medications, such as antidepressants or lithium, can be important treatment, especially for the more serious and recurrent forms of depression.

ADOLESCENT DEPRESSION

Depressive illnesses appear to be occurring more commonly among

teenagers. Many young people, whose symptoms are chalked up to the "normal adjustments" of adolescence, do not get the help they need. Some become so despairing—believing their problems insoluble—that they try to kill themselves, and many actually do so. During the past three decades, suicide among adolescents has increased 300 percent.

While depression is not the only cause of teenage suicide, it is a major one and certainly the cause of much pain as well. Depressed adolescents, like depressed people in any age group, can experience feelings of emptiness, anxiety, loneliness, helplessness, hopelessness, guilt, loss of confidence and self-esteem, and changes in sleeping and eating habits. In addition, they often "act out." That is, they try to "cover" their depression by acting angry, aggressive, running away or becoming delinquent.

Manic-depressive disorder in adolescents is often manifested by episodes of impulsivity, irritability, and loss of control alternating with periods of withdrawal. This treatable disorder typically goes unrecognized when it is assumed that such storminess is natural to adolescence.

Since adolescents are noted for their quickly changing moods and behavior, it may take careful watching to see the differences between a depressive disorder and normal behavior. The key to recognizing the depressive disorder is that the change in behavior lasts for weeks or longer. Any youngster who has four or more symptoms of depression for longer than a few weeks, or who is doing poorly in school, seems socially withdrawn, uncaring, overly impulsive, and no longer interested in activities once enjoyed, should be checked for a possible depressive illness. Depression in adolescents can and should be treated.

DEPRESSION AMONG THE AGED

The wide range of estimates for occurrence

of depression among older populations—from 10 percent to 65 percent—attest to the difficulties of diagnosing depression in an elderly person. Symptoms of depression are often misdiagnosed as senility (organic brain syndrome) or mistaken for the everyday problems of the aged.

For example, the memory loss, confused thinking, or apathy symptomatic of senility actually may be due to depression. On the other hand, early awakening and reduced appetite typical of depression are common among many older persons who are not depressed.

While there is confusion, and some controversy, about how much clinical depression occurs among the elderly, it is known that, on self-report tests, they acknowledge more of the symptoms of depression than any other age group. They also commit suicide at higher rates than other age groups.

Nevertheless, and further complicating diagnosis, elderly persons rarely admit *feelings* of depression, even though they often have much to be depressed about—poor health, loneliness, poverty, or the death of a spouse or other beloved family members or friends. Often they incorrectly attribute their depressive symptoms to physical ailments, and either ignore them or seek inappropriate treatment.

On the other hand, depression does accompany many of the illnesses that afflict older persons, such as Parkinson's disease, cancer, arthritis, and the early stages of Alzheimer's disease. Treating depression in these situations can reduce unnecessary suffering and help afflicted individuals cope with their medical problems.

Medications taken by older persons or inadequate diets, often a problem of older individuals who live alone, can also cause depression as a side effect.

Careful observation by a knowledgeable person, in addition to sophisticated medical evaluation, may be necessary to recognize the depressed older person. A physician attempting to differentiate between senility and depression may call on family members or long-

time friends for information on the patient's history, since the onset of depression is usually more sudden than the slow and gradual process of senility. Also, the individual with organic problems typically minimizes loss of mental function such as memory, while the depressed person exaggerates the loss.

Treatment of the elderly, if antidepressants are indicated, can be complicated by physical problems in addition to diagnostic problems. The older person is more apt to have a complex set of physical ailments for which various drugs are taken. Before prescribing an antidepressant, a physician must carefully consider all other drugs used by the patient, particularly those for heart conditions, to avoid unwanted side effects. Also, because the elderly metabolize drugs more slowly than younger people, the prescribing physician needs to carefully consider and monitor the dosage and efficacy of antidepressants.

Difficulties aside, appropriate treatment of the depressed older person, as with younger individuals, can bring relief from suffering and offer a new lease on life and renewed productivity. There is no justification for anyone of any age to suffer needlessly from depression.

HELPING THE DEPRESSED PERSON

Perhaps the most important thing family and friends can do is encourage the depressed person to get appropriate treatment. The very nature of depression—the feelings of helplessness, hopelessness, and worthlessness—can keep the depressed person from seeking help. When symptoms linger beyond a reasonable time, or if there seems no apparent reason for the individual's persistent feelings of unhappiness and gloom, the observant and caring friend or relative will help the depressed person get professional assistance.

Family and friends can also provide much needed support, love, and encouragement. Depression destroys self-esteem and

confidence, and family and friends can help the depressed person feel worthwhile by applying the following "DOs" and "DON'Ts":

DO

- maintain as normal a relationship as possible.
- point out distorted negative thinking *without* being critical or disapproving.
- acknowledge that the person is suffering and in pain.
- smile and encourage honest effort.
- offer kind words and pay compliments.
- express affection.
- show that you care, respect, and value the depressed person.

DON'T

- blame the depressed person for his or her condition.
- criticize, pick on, "put down" or voice disapproval until the depressed person is feeling better.
- say or do anything to exacerbate his or her poor self-image.

In addition, friends and family can help by keeping the depressed person busy and active. Depression tends to feed on itself, and a moderately depressed person becomes apathetic and inactive leading to more depression, more withdrawal, and more inactivity, resulting in a vicious cycle. Gentle assertiveness may be required to stand by the depressed person, particularly if the individual is withdrawn and rejecting.

Depression typically involves strong feelings of guilt, and it is important that family and friends do not compound such feelings by blaming the individual for his or her symptoms. Depressed people often arouse anger in others, and it is tempting to become impatient, to tell the depressed person to snap out of it, or to indicate that depression is a sign of weakness. The depressed person is in pain and needs understanding and help.

Also, the possibility of suicide must always be considered in cases of depression. Though a depression may appear relatively mild, it does not ex-

clude the possibility of suicide. Sometimes seemingly mild depression has much deeper roots. Nor is it true, as many people believe, that a person who talks about suicide will not attempt it. Those who attempt suicide often appeal first for help by threatening to do so.

Even when there appears little or no danger of suicide, a mental health professional should be consulted when a serious depressive disorder is suspected. The earlier the depressed person receives help, the sooner the symptoms are alleviated and the speedier the recovery.

Depression is the most treatable of all the mental illnesses. Individuals no longer have to suffer its debilitating symptoms. With modern treatment methods, they can return to busy, full, and productive lives.

WHERE TO RECEIVE TREATMENT

Family physicians, clinics, and health maintenance organizations, usually the first health contact of a depressed person, can treat or provide referrals to mental health specialists.

Community mental health centers provide assistance at a cost commensurate with the patient's ability to pay. For a listing of community mental health centers, write to the National Institute of Mental Health, Public Inquiries, Room 15C-05, 5600 Fishers Lane, Rockville, MD 20857.

Some hospitals and universities have special research centers that study and treat depression. Anyone interested in participating in a study can write to the National Institute of Mental Health at the above address for a list of such centers.

Information about centers that specialize in treating depressive disorders can also be received by writing to The National Foundation for Depressive Illness, 20 Charles Street, New York, New York 10014.

If information on private sector practitioners is preferred, references can

be received from your local Mental Health Association (MHA). The national MHA office is located at 1021 Prince Street, Alexandria, Virginia 22314.

Another consumer organization, specifically devoted to assisting individuals with depressive disorders, has chapters in various locales around the country: National Depressive and Manic Depressive Association, Merchandise Mart, Box 3395, Chicago, Illinois 60654.

☆ U.S. GOVERNMENT PRINTING OFFICE : 1986 - 166-211